DIAGNOSTIC ELEMENT

REASON FOR THE 2011 REVISION

This manual presents the 2011 version of the Diagnostic Element of the CDER. The diagnostic codes to be entered should be selected from the 10th Revision of the International Classification of Diseases (ICD-10) set of codes, which replaces the ICD-9 set of codes.

REASON FOR THE 2008 REVISION

Certain items in the Diagnostic Element of CDER were revised (in 2008) to be in compliance with current nomenclature. In particular, item 23 has been revised to allow reporting of conditions representing variants of Pervasive Developmental Disorder / Autistic Spectrum of disorders. Additionally, item (33) specifying the presence of a qualifying disability other than Mental Retardation, Cerebral Palsy, Epilepsy, and Autism was modified. A summary of changes can be found in Appendix A.

Source of Diagnostic Data: The diagnostic information for this form should be provided primarily by the client's physician and psychologist. The medical diagnoses shall be made by the physician. Diagnoses of mental disorders shall be made by those persons qualified to utilize the *DSM-IV-TR* system. Other information required for this form should be provided by persons most qualified to provide accurate data.

Multiple Diagnoses: Information on the various developmental disabilities-mental retardation, cerebral palsy, etc. – is arranged in separated sections on the form. For each section, information on "etiology" or contributing factors" is requested, using ICD-10 codes. Two seven digit spaces are allotted for the ICD-10 coding of each disability. This permits entering both the major or primary cause and secondary or contributing cause for each disability. When a client has more than one developmental disability, it is possible the same causal factor(s) have been found to be associated with the several conditions. For example, a premature infant with anoxic brain damage might have mental retardation, cerebral palsy and epilepsy. The ICD-10 codes for the prematurity and anoxic brain damage would then be entered for each of the three disabilities.

Coding of "Risk Factors": To provide more precise information for prevention planning, a series of "risk factors" or factors that could contribute to or be associated with the occurrence of developmental disabilities has been identified. The factors that include teenage pregnancy, accidents of near drowning, family history of mental retardation, and so forth, have been developed to permit classification of special conditions associated with the occurrence of developmental disabilities. The section on Risk Factors, items 35-49, follows the sections on the specific developmental disabilities.

Organization of Manual: In the following pages the various developmental disabilities and other diagnostic information are presented sequentially, in a series of

sections that correspond to the items on the form. For each item within a section, a description on the item or concept is given first, followed by coding instructions and, usually, an example. Item numbers given in the left margin in the manual refer to item numbers on the revised CDER form.

Eligibility Determination and CDER: The CDER is not an eligibility-determination document. Decisions about the client's eligibility for services are made separately, by the persons designated by the regional center to make such decisions, and usually prior to completion of the CDER form. CDER is a document on which data are recorded for clients found to be eligible for regional center services through other mechanisms. The various categories of information included on the CDER form are not intended to define eligibility, either for the system or for individual clients. CDER simply provides a descriptive data base about clients; neither the individual items nor the particular examples of coding included in the CDER Manual should be interpreted as guidelines for eligibility decisions.

Etiology: The term "Etiology" on the CDER form refers to those factors that may have contributed to or been associated with the client's developmental disability or medical condition. Recording a factor or condition in an "Etiology" item on CDER is not a statement of definitive causation in any medical-legal sense. These factors or associated conditions are to be used for review and statistical purposes only and do not constitute a diagnostic opinion as to the exact cause of a developmental disability or medical condition.

MENTAL RETARDATION

Mental Retardation refers to significantly sub-average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period, where general intellectual functioning is the results obtained by assessment with one or more individually administered standardized general intelligence tests; significantly sub average is intelligence quotient of 70 or below on standardized measures of intelligence; impairments in adaptive behavior is significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that is expected for age and cultural group, as determined by clinical assessment and usually standardized scales; and developmental period is that period of time prior to the 18th birthday. "Developmental deficits" may be manifested by slow, arrested, or incomplete development resulting from brain damage, degenerative processes in the central nervous system (CNS) or regression due to psychosocial factors.

11. LEVEL OF MENTAL RETARDATION (ICD-10 Code)

This item refers to the severity or level of the client's mental retardation. The appropriate three digit ICD-10 code is to be used to record this information.

The level of retardation is determined by considering both the level of general intellectual functioning as obtained by one or more individually administered intelligence quotient (I.Q.) tests and the level of the client's adaptive behavior.

Typically, intellectual functioning and adaptive behavior are measured by standardized tests, the results of which form the basis for the psychologist's clinical diagnosis. Determination of the level of Mental Retardation, level of intellectual functioning, and level of adaptive behavior must be consistent with DSM-IV-TR. The level of Mental Retardation should be obtainable from a psychological evaluation report or other source in the client's records.

The ICD-10 codes below represent the various levels of Mental Retardation. Enter the appropriate code in Item 11.

Mental Retardation Level Codes

0	No Retardation
F70	Mild
F71	Moderate
F72	Severe
F73	Profound
F79	Unspecified (level)

Use category F79, MR unspecified (level) in the following situations:

- If the client has mental retardation, but the level of retardation is not given.

- As a temporary coding until a determination can be made.

- If there is a strong belief that the person has mental retardation but for any number of reasons cannot be tested by standard intelligence tests; for example, the client is too impaired or uncooperative, or one or both I.Q. and adaptive behavior measure are lacking.

- If there is no information in the client's record regarding his/her mental retardation level or a proper diagnosis cannot be made.

Example of Coding Level of Retardation

Example 1: Consumer has severe mental retardation.

Level of Retardation (ICD-10 Code)

11. |F72 |

0	No Retardation
F70	Mild
F71	Moderate
F72	Severe
F73	Profound
F79	Unspecified (level)

12a. and 12b. ETIOLOGY OF MENTAL RETARDATION

Items 12a and 12b are to be used to record the major cause(s) of the client's Mental Retardation. ICD-10 codes are to be used.

- If the client does not have mental retardation, enter 0 in Item 12a and leave Item 12b blank.

- If the client has mental retardation and the cause or contributing factor is known, enter the appropriate ICD-10 code in Item 12a; if more than one causal factor is known, record the additional factor in item 12b using the appropriate ICD-10 code.

- If the client has mental retardation but etiological factors are not known, enter "0" in Item 12a and leave Item 12b blank.

NOTE: ***Risk factors and associated conditions related to the mental retardation, as well as to all other developmental disabilities, are to be coded in items 35-49. Manual instructions for these are provided in sequence below.***

Example of Coding Etiology of Mental Retardation

Example 1: Consumer is an infant with Down Syndrome who had subsequent brain damage due to lack of oxygen at birth.

Down Syndrome, unspecified (primary cause)	= code	Q90.9
Severe Birth Asphyxia (secondary cause)	= code	P21.0

Etiology of Mental Retardation	ICD-10 Code
12a. (Down Syndrome, unspecified)	|Q90.9 |
12b. (Severe Birth Asphyxia)	|P21.0 |

13. DATE OF LAST EVALUATION

This is the most recent date (month and year) on which the last determination or review of the client's mental retardation level was made. It usually will be found in the psychologist's report.

If Item 11 is coded "0" or if there is no psychological evaluation report in the client's records, enter "0" in the boxes for this item.

The remaining items in this section are applicable to developmental center clients only. They may be, but do not have to be, completed for other regional center clients.

Date of Last Evaluation

M	**M**	**Y**	**Y**	

14. INTELLIGENCE QUOTIENT SCORE

Enter here the three-digit numerical Intelligence Quotient (I.Q.) which best represents the client's level of mental retardation, for example, 047. If the client has previously been evaluated, there should be a psychological evaluation report in which the psychologist will report one number as best representing the client's I.Q. If more than one number is reported, ask the client's psychologist to give and document the one best representative number. ***This item cannot be scored unknown or left blank for developmental center clients.***

15. INTELLIGENCE TEST NAME

Select the two-digit code listed in Appendix F for the test used to give the I.Q. (actual or estimated) in Item 14. If more than one test is used, select the one that is given primary weight. If the test is not listed, or if the client's I.Q. has been determined by other means, use code 22 or 27, respectively.

Examples of Coding Client's Intelligence Quotient and Intelligence Test

Example 1: Consumer's most representative score was 67 on the Vineland Social Maturity Scale.

Developmental Center Clients Only

Intelligence Quotient

14. | 0 | 6 | 7 |

Intelligence Test

15. | 2 | 3 |

Example 2: Consumer's intelligence quotient of 55 was determined by means other than one of the tests on the list:

Intelligence Quotient

14. | 0 | 5 | 5 |

Intelligence Test

15. | 2 | 7 |

16. ADAPTIVE BEHAVIOR RATING

This item refers to the level of the client's ability to meet standards of maturation, learning, personal independence, and/or social responsibility that is expected for his/her age and cultural group. Adaptive behavior is used in conjunction with the intelligence quotient in determining mental retardation level.

The codes below represent the various levels of Adaptive Behavior. Enter the appropriate code, as listed below, in the space provided.

Adaptive Behavior Rating Codes

0 Normal
1 Mild
2 Moderate
3 Severe
4 Profound
5 Unknown

If the client has been previously evaluated, there should be a rating in the records. Enter the appropriate code "0" – "4". If there is nothing to indicate the client's adaptive behavior rating, enter "5" for unknown.

Example of Coding Adaptive Behavior Rating

Example 1: The client below has a moderate adaptive behavior rating.

Adaptive Behavior Rating

16. | 2 | 0 Normal
1 Mild
2 Moderate
3 Severe
4 Profound
5 Unknown

CEREBRAL PALSY

The term Cerebral Palsy (CP) refers to a group of non-progressive lesions or disorders in the brain characterized by paralysis, spasticity, or abnormal control of movement or posture, such as poor coordination or lack of balance. These disorders may be due to developmental anomalies of the central nervous system or injury of the brain during intrauterine life, the perinatal period, or within the first few months of life, and are usually manifested during early childhood.

Common prenatal causes of CP are maternal infections such as toxoplasmosis, rubella, and cytomegalic inclusion disease. Examples of perinatal causes are cerebral trauma, anoxia, or intracerebral bleeding during birth. In the first few months of life, important etiological factors are kernicterus, meningitis, encephalitis, or child abuse.

Although diagnoses of later-onset neurological disorders (e.g., cerebrovascular disease and tumors) and well-defined neurodegenerative diseases (e.g., Early Onset Primary Dystonia or Friedreich Ataxia) are excluded from this CP definition, the motor dysfunction associated with such conditions are similar to CP and, therefore, should be coded in this section.

In this section, attention is given both to Cerebral Palsy and to other conditions with motor dysfunction that are similar to Cerebral Palsy. Items are provided below for recording either Cerebral Palsy or other significant motor dysfunction. For example, if an older child with homocystinuria suffered a stroke, causing severe left cerebral damage in the motor area giving rise to a right hemiplegia, the code for motor dysfunction similar to CP could be used. In this example, the items for etiology would be reflected by codes A52.05 (Other Cerebrovascular Syphilis) and E7211 (homocystinuria).

17. PRESENCE OF CEREBRAL PALSY

This item is for recording whether the consumer has Cerebral Palsy or some other condition that produces a significant motor dysfunction.

Presence of Cerebral Pals*y*

0 No CP or other significant motor dysfunction
2 Has CP
3 Has other significant motor dysfunction

When coding Presence of Cerebral Palsy

- If the consumer does <u>not</u> have Cerebral Palsy or another condition that produces a significant motor dysfunction, enter a "0" in Item 17 and leave Items 18a-22 blank.
- If the consumer has Cerebral Palsy, enter code "2"; then complete Items 18a-22.

- If the consumer has a condition that produces a significant motor dysfunction, enter code “3”; then complete Items 18a-22.

Example of Coding Presence of Cerebral Palsy

Example 1: Consumer has been diagnosed with Cerebral Palsy.

17. | 2 | **Presence of Cerebral Palsy**

0 No CP or other significant motor dysfunction

2 Has CP

3 Has other significant motor dysfunction

18a & 18b. ETIOLOGY OF CEREBRAL PALSY

The Etiology items are used to record the major cause(s) of or contributing factor(s) to Cerebral Palsy or other significant motor dysfunction. Record the etiologic factor(s) using ICD-10 codes. Etiology does not mean the severity, type, or location of motor dysfunction. These descriptors are addressed as separate items and are discussed in detail later in this section.

- If the consumer does not have Cerebral Palsy or other significant motor dysfunction, as indicated in Item 17, leave this item blank.
- If the consumer has Cerebral Palsy or other significant motor dysfunction, enter the appropriate ICD-10 code that indicates the major cause or factor contributing to the disability in the seven spaces provided in Item 18a. Add any additional factor in Item 18b.
- If the etiology of the consumer's motor dysfunction is not known, enter “0” in Item 18a and leave Item 18b blank.

NOTE*: Any risk factors associated with, but not directly causing, the disability should be recorded in Items 35-49.*

Example of Coding Etiology of Cerebral Palsy

Example 1: Consumer was born prematurely with hemolytic disease due to RH isoimmunization.

	Etiology ICD-10 Code
18a. (RH isoimmunization)	|P550 |
18b. (Prematurity)	|P558 |

19. SEVERITY OF MOTOR DYSFUNCTION

This item refers to the severity of disability caused by Cerebral Palsy or other significant motor dysfunction.

The categories used to indicate the severity or degree of impairment of Cerebral Palsy or other type of significant motor dysfunction are mild, moderate, and severe; however, there are no commonly accepted standards. Refer below for definitions of the severity of impairment as they pertain to this manual.

Prior to rating the consumer's severity of motor dysfunction, make certain that the correct entry has been made in **Presence of Cerebral Palsy** (Item 17), indicating whether or not Cerebral Palsy or another significant motor dysfunction is present.

The categories for Severity of Motor Dysfunction are as follows:

Severity of Motor Dysfunction

Mild: Condition exists but does not have limiting effects on daily activities and functions.

Moderate: Level of impairment is between mild and severe with respect to performance of daily activities and functions.

Severe: The disability significantly limits or precludes daily activities and functions.

Severity of Motor Dysfunction Codes

1 Mild: Does not limit activities.

2 Moderate: In between mild and severe.

3 Severe: Significantly limits or precludes daily activity.

When Coding Severity of Motor Dysfunction

- If the consumer does <u>not</u> have Cerebral Palsy or other type of significant motor dysfunction (a "0" in Item 17), leave this item and subsequent items in this section blank.

- If the consumer is diagnosed as having Cerebral Palsy or other significant motor dysfunction, enter the appropriate code as listed above.

Example of Coding Severity of Motor Dysfunction

Example 1: Severity of motor dysfunction significantly limits consumer's daily activities and functions.

19**. |3| Severity of Motor Dysfunction**

1 Mild: Does not limit activities.

2 Moderate: In between mild and severe.

3 Severe: Significantly limits or precludes daily activity.

20. TYPE OF MOTOR DYSFUNCTION

The type of motor dysfunction should be included in the consumer's records. The categories used for this item are defined below:

Type of Motor Dysfunction Definitions

Hypertonic (includes Spasticity and Rigidity): Hypertonia is defined as a "state of increased muscle tension." The major manifestation of spasticity is increased or exaggerated stretch reflex that exhibits itself by an exaggerated contraction of a muscle when it is suddenly stretched. Rigidity is a form of hypertonia that is independent of the speed or range of movement.

Ataxic: This type of motor dysfunction is characterized by "disturbance in postural balance and coordination of muscle activity; usually generalized but may be confined to one side of body or one extremity."

Dyskinetic (includes Athetosis, Dystonia, Chorea, and Ballismus): Dyskinetia, or involuntary movements, may be of four types—athetosis, dystonia, chorea, and ballismus.

- Athetosis is uncontrollable, involuntary and poorly coordinated movements of body, face, and extremities that result in bizarre patterns of muscular activities.

- Dystonia is persistent deviation of a body part due to abnormal muscle contraction. Partial or incomplete dystonia may consist of a tendency to abnormal deviation that can be overcome (at least temporarily) by volitional corrections; repetitious movements may result from this interaction between voluntary and involuntary movements.

- Chorea is faster than athetosis and is typically seen in the trunk and large muscles of the extremities. The motion is jerky, random and complex. The involuntary movement is often incorporated into a voluntary motion.

- Ballismus is a very fast and forceful movement, typically in the shoulder but may include the hips. Ballismus may occur with athetoid and choreiform movements.

Hypotonic: This type of motor dysfunction is characterized by a "lack of normal muscle tone or tension associated with muscle flaccidity and weakness."

Other: This category includes mixed motor dysfunctions.

(Refer to pages below for examples of coding *Type of Motor Dysfunction*)

21. LOCATION OF MOTOR DYSFUNCTION

This item refers to the areas of the body that are affected by a motor dysfunction. The categories used for this item are defined below:

Location of Motor Dysfunction Definitions

Monoplegia: Involves weakness or paralysis of a single extremity.

Hemiplegia: Involves both upper and lower extremities on one side.

Diplegia: Involves both sides of the face, both upper extremities, and/or both lower extremities. One area is usually more involved than the other.

Triplegia: Involves three extremities.

Paraplegia: Involves lower-extremities only.

Quadriplegia: Involves all four extremities.

Other: Not otherwise specified.

(Refer to pages below for examples of coding Location of Motor Dysfunction)

22. CONDITION IMPACT

Condition Impact refers to the extent or degree to which Cerebral Palsy or other significant motor dysfunction determines level of supervision, level of care, ability to maintain a stable residence, and/or type of individual program services. The categories used for this item are defined below:

Condition Impact Definitions

None: No evidence of impairment.

Mild: Condition requires some special attention when developing the individual program plan or planning for supervision and care.

Moderate: Condition has a major impact upon the individual's need or program services and/or supervision and care.

Severe: Condition is so substantial that it will require significant planning and coordination for service delivery and/or supervision and care.

Condition Impact Codes

0 No evidence of impairment
1 Mild
2 Moderate
3 Severe

When Coding Condition Impact on the Hard-Copy Form

- If the consumer does not have Cerebral Palsy or other type of significant motor dysfunction (code "0" in Item 17), leave this item (Item 22) blank.

- If the consumer has Cerebral Palsy or other type of significant motor dysfunction, but it does not have an impact upon the level of supervision and/or care required or on the individual program plan, enter code "0" ("No Evidence of Impairment").

Examples of Coding Type, Location & Condition Impact

Example 1: This example is of a consumer with Spastic Quadriplegia, the impact of which on supervision/care and individual planning process is mild.

20. |1| Type of Motor Dysfunction
1 Hypertonic (includes Spasticity and Rigidity)
2 Ataxic
3 Dyskinetic (includes Athetosis, Dystonia, Chorea, and Ballimus)
4 Hypotonic
5 Other (includes mixed)

21. |6| Location of Motor Dysfunction
1 Monoplegia
2 Hemiplegia
3 Diplegia
4 Triplegia
5 Paraplegia
6 Quadriplegia
7 Other

22. |1| Condition Impact

Example 2: This example is of a consumer with bilateral upper limb reduction causing motor dysfunction. The condition involves the upper extremities on both

sides of the body and has a severe impact on supervision/care and individual program planning.

20. |5| Type of Motor Dysfunction

1 Hypertonic (includes Spasticity and Rigidity)
2 Ataxic
3 Dyskinetic (includes Athetosis, Dystonia, Chorea, and Ballimus)
4 Hypotonic
5 Other (includes mixed)

21. |3| Location of Motor Dysfunction

1 Monoplegia
2 Hemiplegia
3 Diplegia
4 Triplegia
5 Paraplegia
6 Quadriplegia
7 Other

22. |3| Condition Impact

AUTISM

Autism is a lifelong neuro-developmental disorder that often has a genetic origin. It is presumed to be present from birth and is usually apparent before the age of three. Autism is a developmental disability that strikes more males than females and affects the individual's ability to communicate, understand language, play, and interact with others. Autism is a behavioral syndrome; its definition and clinical diagnosis are determined by patterns of behaviors that a person exhibits. Although autism affects the functioning of the brain, in most cases the specific cause(s) of autism are unknown. It is widely assumed there are multiple causes, and there are different subtypes of autism. The term Pervasive Developmental Disorder (PDD) refers collectively to five different disorders with common clinical features. For a detailed description of the PDD's, see the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).

Because persons with autism share common core deficits but also have significantly different clinical presentations, most professionals view this range of deficits as a "spectrum disorder." As a result, Autistic Spectrum Disorder (ASD) is an increasingly popular term that generally refers to just three of the five PDD's. ASD includes the classical form of the disorder (Autistic Disorder) and two closely related disorders: Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS) and Asperger Disorder, both of which share the core characteristics of autism.

An individual is diagnosed as having PDD-NOS if he or she has some behaviors seen in autism but does not meet the full DSM-IV-TR criteria for having Autistic Disorder. The DSM-IV-TR indicates that the diagnostic label of PDD-NOS be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or the development of repetitive behavior, interests, and activities, but only when the criteria are not completely met for another specific disorder within the broader category of the Pervasive Developmental Disorders (e.g., Autistic Disorder, Asperger Disorder, Rett Syndrome, or Childhood Disintegrative Disorder). There is no set pattern of symptoms and signs in children with PDD-NOS. Symptoms vary in severity, atypicality and age of onset. A single child seldom shows all the features seen in PDD-NOS at one time. All children with PDD-NOS do not have the same degree or intensity of the disorder. PDD-NOS can be mild, with the child exhibiting only a few symptoms while in the school or neighborhood environment. Other children may have a more severe form of PDD-NOS and have difficulties in all areas of their lives. PDD-NOS, as a diagnostic classification, includes Atypical Autism. The important issue is that a competent, well-trained and experienced clinician conducts the diagnostic evaluation, and that a complete differential diagnosis be considered before determining a PDD-NOS diagnosis.

Asperger Disorder, like Autistic Disorder, is characterized by marked and sustained difficulties in social interaction and emotional relatedness, and by patterns of circumscribed interests and behavioral peculiarities. In Asperger Disorder, there are no significant delays in language or cognitive development.

The two remaining PDD's listed in the DSM-IV-TR (i.e., Rett Syndrome and Childhood Disintegrative Disorder) are differentiated by their unique etiologies or associated clinical features; they are not appropriate for classification as Ads. Rett Syndrome has a known genetic etiology that is a mutation of the MECP2 gene on the long arm of the X chromosome; typically it affects only females and presents with hard neurological signs, including mental retardation and seizures that become more apparent with age. Childhood Disintegrative Disorder (CDD), an extremely rare PDD, refers to children whose development appears normal for at least two years after birth but then regresses before age 10 with the loss of speech and other skills until severe mental retardation and autistic characteristics are conspicuous.

Formal diagnostic criteria for Autistic Disorder, and other PDD's are presented in the DSM-IV-TR. For assistance with understanding DSM IV diagnostic criteria and how the Ads are diagnosed, see *Autistic Spectrum Disorders, Best Practice Guidelines for Screening, Diagnosis and Assessment* (Department of Developmental Services, 2002).

23a. PRESENCE OF AUTISTIC DISORDER

This item is for recording whether the consumer has been diagnosed with Autistic Disorder. This is recorded in Item 23a as follows:

Presence of Autistic Disorder

0 None (No Diagnosis)

1 Autistic Disorder

When Coding Presence of Autistic Disorder

- If the person does <u>not</u> have Autistic Disorder, enter a "0" in Item 23a and leave Items 24a, 24b, 25 and 26 blank.

- If the person has been diagnosed with Autistic Disorder, enter a "1" in Item 23a.

23b. PRESENCE OF OTHER PERVASIVE DEVELOPMENTAL DISORDER

This item is for recording whether the consumer has been diagnosed with Asperger Disorder or Pervasive Developmental Disorder, NOS, as follows:

None (No Diagnosis)
Asperger Disorder
Pervasive Developmental Disorder, NOS

Note: Asperger Disorder and PDD-NOS are for informational recording only; they are not categorically eligible conditions. Individuals with these disorders are eligible only if they meet the Fifth Category requirements for eligibility.

Note: Rett Syndrome and Childhood Disintegrative Disorder (CDD) are **NOT** recorded in this section. Those disorders are appropriately recorded under the Mental Retardation or Epilepsy Section of the CDER. The specific ICD-10 code for Rett Syndrome or CDD is entered under Etiology in the corresponding sections of the CDER Diagnostic.

Presence of Other Pervasive Developmental Disorder

0 None (No Diagnosis)
3 Asperger Disorder
4 Pervasive Developmental Disorder, NOS

When Coding Presence of Other Pervasive Developmental Disorder

- If the person does not have one of the diagnoses listed above, enter a "0" in Item 23b and leave Items 24a, 24b, 25 and 26 blank.

- If the person does have one of the diagnoses listed above, enter the code for the disorder that conforms to the diagnostic conclusion or diagnostic impression documented in the person's chart in Item 23b, and complete items 24a, 24b, 25 and 26.

Note: Other Important Considerations When Recording Presence of Autistic Disorder or Other Pervasive Developmental Disorder

Persons with Autistic Disorder or Other Pervasive Developmental Disorder sometimes have co-existing conditions that should be recorded in other sections of the CDER as described below:

- Co-existing diagnoses of mental retardation, epilepsy or cerebral palsy, should be recorded in the Mental Retardation, and/or Epilepsy/Seizure Disorders, and/or Cerebral Palsy section(s) as applicable.

- Co-existing psychiatric diagnoses, including DSM-IV-TR *Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence* should be entered under Axis I or Axis II in the Psychiatric Disorders section. Examples of psychiatric and/or behavioral disorders are mood disorders, aggression, impulsivity and withdrawal.

(See Example 3 below for completing the CDER when a person has Autistic Disorder and other co-existing conditions)

24a & 24b. ETIOLOGY

The etiology of Autistic Disorder or other PDD is rarely known, but in cases where causative links are known, it should be documented in this section. Etiology refers to the cause(s) of the disorder or factors known to produce or predispose an individual toward the disorder. The resultant final (behavioral) expression of Autistic Disorder or other PDD is presumably linked to underlying neurological and other

medical disorders. Conditions listed in this section should include only the underlying etiology, if it is known. Examples of a few known medical conditions etiologically related to Autistic Disorder or other PPD are structural brain lesions, chromosomal syndromes, congenitally acquired infections, in-utero drug exposure, inherited metabolic disorders, and the neurocutaneous syndromes.

- If the person does not have Autistic Disorder (code "0" in Item 23a) or Other Pervasive Developmental Disorder (code "0" in Item 23b), leave both Item 24a and Item 24b blank.

- To enter an identified etiology, enter the appropriate ICD-10 code in Item 24a (and Item 24b if needed).

- If the person's etiology is unknown, enter "0" in Item 24a and leave Item 24b blank.

(See Example 1 below for completing this item when Etiology is identified)

25. DATE OF DIAGNOSIS

The date of diagnosis is the date (month and year) that a formal diagnosis was determined. If the diagnosis changes subsequent to a later diagnostic evaluation, then the most recent diagnosis is recorded with a new date of diagnosis.

When Recording Date of Diagnosis:

- If the person does not have Autistic Disorder or Other Pervasive Developmental Disorder, leave this item blank.

- If the person has Autistic Disorder or Other Pervasive Developmental Disorder, enter the date on which the person was diagnosed.

- If the person has Autistic Disorder or Other Pervasive Developmental Disorder, but the date of diagnosis is not in the consumer's record, a reasonable effort should be made to determine the date. If, after such effort, the date cannot be determined, the pseudo-date 01/00 should be entered.

26. CONDITION IMPACT

The extent or degree of impact is determined by the person's level of supervision, level of direct care, ability to maintain a stable residence, and the likelihood of succeeding or failing in a program and/or the educational system. The categories used for this item are defined below.

Condition Impact Definitions

None: No Evidence of Impairment.

Mild: Condition requires limited special attention when planning for the person's school or day program, living arrangements, and/or extra supervision or care. For example, the person is living at home and is receiving minimal behavioral intervention or other special services.

Moderate: Condition has a major impact upon the ability to obtain an appropriate school or day program, residential placement, and/or it requires a considerable amount of supervision or care. For example, the person lives at home or is in a community residential setting and needs moderate behavioral intervention such as a one-to-one aide at school but not at home.

Severe: Condition is so substantial that it is exceedingly difficult to find an appropriate program or residence for the person and/or constant supervision/care is required. For example, the person is at home or in a residential setting and needs extensive professionally supervised behavior intervention services, such as in-home behavioral supports provided on a one-to-one basis.

Condition Impact Codes

0 No Evidence of Impairment
1 Mild
2 Moderate
3 Severe

When Coding Condition Impact

- If the person does <u>not</u> have Autistic Disorder or Other Pervasive Developmental Disorder (code “0” in Item 23), leave this item blank.

- If the consumer has Autistic Disorder or Other Pervasive Developmental Disorder but it does not have an impact upon level of supervision, level of direct care, ability to maintain a stable residence, and the likelihood of succeeding or failing in a program and/or the educational system, enter code "0" (“No Evidence of Impairment”).

(See Example 2 below for completing Condition Impact)
<u>Examples of coding Presence of Autistic Disorder, Etiology, Condition Impact, and Co-Existing Conditions</u>

Example 1: This example shows the coding for a child diagnosed with Autistic Disorder who has medical documentation of tuberous sclerosis, a condition that causes autistic symptoms in 2 to 4 percent of cases, which would be coded for etiology. In this example, the ICD-10 code for tuberous sclerosis is Q851.

Completing the CDER Form For Example 1:

23a . |1 | **Presence of Autistic Disorder**

0 None (No Diagnosis)
1 Autistic Disorder

23b. |0 | **Presence of Other Pervasive Developmental Disorder**

0 None (No Diagnosis)
3 Asperger Disorder
4 Pervasive Developmental Disorder, NOS

Etiology (ICD-10 Code)

24a. |Q851 |

Etiology (ICD-10 Code)

24b. | |

Example 2: This example shows the coding for a person who is severely impacted by autistic disorder. This person is receiving 24-hour supervision and daily behavioral intervention in a community residence and at school and has significant deficits in self-help skills, and/or is severely disruptive or engages in self-injurious behavior.

Completing the CDER Form For Example 2:

23a . |1 | **Presence of Autistic Disorder**

0 None (No Diagnosis)
1 Autistic Disorder

23b. |0 | **Presence of Other Pervasive Developmental Disorder**

0 None (No Diagnosis)
3 Asperger Disorder
4 Pervasive Developmental Disorder, NOS

26. |3 | **Condition Impact**

Example 3: This example shows the coding for a person with a diagnosis of Autistic Disorder with co-existing mental retardation (mild) and a generalized seizure disorder manifested by occasional Petit Mal seizures.

Completing the CDER Form For Example 3:

23a . |1 | Presence of Autistic Disorder

0 None (No Diagnosis)
1 Autistic Disorder

23b. |0 | Presence of Other Pervasive Developmental Disorder

0 None (No Diagnosis)
3 Asperger Disorder
4 Pervasive Developmental Disorder, NOS

Etiology (ICD-10-CM Code)

24a. | |

24b. | |

25. | | | | | **Date of Diagnosis**
M M Y Y

26. | | **Condition Impact**

(Note: The Etiology of Autistic Disorder, if it is known, should be recorded under Item 24)

Epilepsy/Seizure Disorder

Type of Seizure

27a. | 4 | 28a. | | 29a. | |

0 Does not have seizure disorder
1 Partial, Simple
2 Partial, Complex
4 Generalized, Absence (Petit Mal)
6 Generalized, Infantile Spasms
7 Generalized, Tonic-Clonic (Grand Mal)
9 Other/Unclassified Seizures

Seizure Frequency

27b. | 3 | 28b. | | 29b. | |

1 History of seizures, none in two years
2 History of seizures, none in one year
3 One to six per year
4 Seven to 11 per year
5 One per month (approximate)
6 One per week (approximate)
7 One per day (approximate)
8 More than one per day
9 Frequency Undetermined

(**Note:** Items 27c, 28c, and 29c should be completed as appropriate to indicate Condition Impact. Etiology of Epilepsy/Seizure Disorder(s), if known, should be recorded in 30a-b. Additionally, Items 31 and 32 should also be completed with the appropriate information)

References

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders – Text Revised. (4th ed.). Washington, DC: Author.

Department of Developmental Services. (2002). Autistic spectrum Disorders: Best practice guidelines for screening, diagnosis, and assessment. Sacramento, CA: Author.

EPILEPSY/SEIZURE DISORDERS

The purpose of the items in this section is to determine the types and causes or classification of seizure disorders. Epilepsy, the most common seizure disorder, is a chronic condition that briefly interrupts the normal electrical activity of the brain to cause unpredictable and recurrent seizures, which alter a person's consciousness, movement or actions for a short time. In order to maintain consistency with current national and international usage, the “International Classification of Epileptic Seizures” is employed. Under this system of classification, seizures are categorized into three main types:

- Partial seizures, which have the onset in a single area of the brain.
- Generalized seizures, which have their onset from widespread and diffuse areas of the brain.
- Unclassified Seizures which includes other types of seizures.

27-29. TYPE OF SEIZURE, FREQUENCY OF SEIZURE, AND CONDITION IMPACT

Type of Seizure (Items 27a, 28a and 29a)
These items are to record the types of seizures experienced by the consumer. The definitions used for these items are as follows:

Does Not Have Seizure Disorder

Partial, Simple: These types of seizures begin locally and are generally without impairment of consciousness. Included in this classification are seizures with associated motor conditions, sensory or somatosensory symptoms, and autonomic symptoms.

Partial, Complex: These types of seizures begin locally and often include impairment of consciousness. These types of seizures have a simple partial onset followed by impaired consciousness.

Generalized, Absence (Petit Mal): In this classification, seizures start in the midline (brainstem) and are bilaterally symmetrical. "Petit Mal" is characterized by "very short episodes of cessation of activity with a fixed staring appearance."

Generalized, Infantile Spasms: These are myoclonic seizures that occur during infancy or very early childhood with EEG pattern of "hypsarhythmia." They involve short generalized muscle contraction; infant suddenly and forcibly flexes the head on the chest and the thighs on the abdomen; may involve over-extension of neck and arching of back; consciousness invariably lost, but the episode is of very short duration.

Generalized, Tonic-Clonic (Grand Mal): These seizures are associated with generalized spiking in the EEG with loss of consciousness, generalized tonic and clonic muscle activity followed by a period of sleep. A sensory or autonomic aura frequently precedes the seizure, which may last from 30 seconds to some minutes.

Other/Unclassified Seizures: This includes seizure disorders not specified above and may be used if undetermined types of seizures are present.

NOTE: Type of Seizure information must be completed for any consumer who has been diagnosed with a seizure disorder, even if the person's seizures are under control through the use of medication.

Seizure Frequency (Items 27b, 28b and 29b)
These items provide an indication of how often the person experiences seizures and whether the person has experienced seizures in the past. Complete these items by

indicating the approximate frequency for each type of seizure that the person currently experiences or has experienced in the past two years, as listed below:

- **History of seizures, none in two years**
- **History of seizures, none in one year**
- **One to six per year**
- **Seven to 11 per year**
- **One per month (approximate)**
- **One per week (approximate)**
- **One per day (approximate)**
- **More than one per day**
- **Frequency undetermined**

Condition Impact (Items 27c, 28c and 29c)

Condition Impact refers to the extent or degree to which the seizure disorder determines level of supervision, level of care, ability to maintain a stable residence, and/or type of individual program services. The categories used for these items are defined below:

None: No evidence of impairment

Mild: Condition requires some special attention when developing the individual program plan or planning for supervision or care.

Moderate: Condition has a major impact upon the individual's need for program services and/or supervision and care.

Severe: Condition is so substantial that it will require significant planning and coordination for service delivery and/or supervision and care.

Completing the CDER Form
Type of Seizure, Seizure Frequency and Condition Impact (Items 27– 29):

Type of Seizure (Items 27a, 28a and 29a)

Enter the appropriate code, as presented below, for Items 27a – 29a:

0 Does not have seizure disorder

1 Partial, Simple

2 Partial, Complex

4 Generalized, Absence (Petit Mal)

6 Generalized, Infantile Spasms

7 Generalized, Tonic-Clonic (Grand Mal)

9 Other/Unclassified Seizures

When Coding Type of Seizure

- If the person does not have a seizure disorder, enter a zero ("0") in Item 27a and leave Items 28a-32 blank.

- If the person has a seizure disorder, enter the appropriate code, as listed above, in 27a. Enter any additional types of seizures in Items 28a and 29a. Up to three distinct types of seizure may be entered for each person.

- If the person has more than one distinct type of seizure, enter the appropriate codes in the respective boxes for Seizure Frequency (Items 27b - 29b) and Condition Impact (Items 27c – 29c). Leave unneeded boxes blank if the person has fewer than three types of seizures.

- The type of seizure should be in the person's medical records with the specified diagnosis. If it is not in the medical records and clarifying information is not available, or if a seizure disorder is suspected but not diagnosed, enter code "9," indicating "Other/Unclassified Seizures" type of seizure in box 27a and leave other boxes blank. .

Seizure Frequency (Items 27b, 28b and 29b)

Enter the appropriate code, as presented below, for Items 27b – 29b:

1	**History of seizures, none in two years**
2	**History of seizures, none in one year**
3	**One to six per year**
4	**Seven to 11 per year**
5	**One per month (approximate)**
6	**One per week (approximate)**
7	**One per day (approximate)**
8	**More than one per day**
9	**Frequency Undetermined**

When Coding Seizure Frequency

- If the person does not have a seizure disorder, leave these items blank.

- Enter the approximate frequency in 27b for the seizure type indicated in 27a.

- If the person has more than one distinct type of seizure, enter the approximate frequency in 28b for the seizure type indicated in 28a and the approximate frequency in 29b for the seizure type indicated in 29a, as appropriate.

Condition Impact (Items 27c, 28c and 29c)

Enter the appropriate code, as presented below, for Items 27c – 29c:

0 No Evidence of Impairment

1 Mild

2 Moderate

3 Severe

When Coding Condition Impact

- If the person does not have a seizure disorder (code "0" in Item 27a) leave these items blank.

- If the person does have a seizure disorder as indicated in Item 27a, enter the corresponding Condition Impact code for that type of seizure in 27c.

- If the person has more than one distinct type of seizure, enter the corresponding Condition Impact code in Item 28c for the seizure type indicated in 28a and the corresponding Condition Impact code in Item 29c for the seizure type indicated in 29a, as appropriate.

(See examples below for recording Seizure Type, Seizure Frequency, and Condition Impact on the CDER form)

30a and 30b. ETIOLOGY OF EPILEPSY/SEIZURE DISORDER

These items are used to record the major cause(s) or contributor(s) to Epilepsy or other type of seizure disorder by selecting the appropriate ICD-10 code.

NOTE: Any Risk Factors associated with the disability should be coded in Items 35-49.

Completing the CDER Form for Items 30a and 30b: Etiology

When Coding Etiology

- If the person does not have Epilepsy or any other type of seizure disorder (code "0" in Item 27a), leave this item blank.

- If the consumer has Epilepsy or other type of seizure disorder, use the appropriate ICD-10 code(s).

- If the person does have Epilepsy or other seizure disorder, but the etiological factors are not known, enter “0” in Item 30a and leave Item 30b blank.

Example of Coding Etiology of Epilepsy/Seizure Disorder

Example 1: The following example shows the coding for a person who has epileptic seizure due to Hemophilus Meningitis:

ICD-10 Code

30a. |G000 |

30b. | |

31. CLIENT TAKES ANTICONVULSANT MEDICATION

This item is included to identify those persons whose seizures are being controlled by medication.

Completing the CDER Form for Item 31: Client Takes Anticonvulsant Medication

- Code this item "1" if the person is taking medication to control seizures.
- Code this item "2" if the person is not taking medication.

Example of Coding Client Takes Anticonvulsant Medication

Example 1: This is an example of coding a person whose seizure disorders are being treated by medication.

Consumer takes anticonvulsant medication
31. |1 | 1 = Yes 2 = No

32. STATUS EPILEPTICUS

Status Epilepticus is defined as continuous seizures lasting twenty minutes or more with no intervening periods of consciousness.

This item is included to determine if the person currently has, or has had, Status Epilepticus in the past year. **The diagnosis of Status Epilepticus must be made by the physician.**

Note: Febrile seizures are not epilepsy and are to be coded in the Major Medical Conditions section.

Completing the CDER form for Status Epilepticus

- If the person does not have a seizure disorder (code "0" in Item 27a) leave this item blank.
- If the person had Status Epilepticus within the past year, enter "1" for Yes in Item 32; if the answer is No, enter a "2."
- If it is not known whether the person had Status Epilepticus, enter "3" for "Not Known."

Examples of Coding Status Epilepticus

Example 1: Person experienced Status Epilepticus nine months ago.

32. |1 | Has the consumer had Status Epilepticus in the past year?
1 = Yes 2 = No 3 = Not Known

Example 2: Person experienced Status Epilepticus 20 months ago.

32. |2 | Has the person had Status Epilepticus in the past year?
1 = Yes 2 = No 3 = Not Known

Examples of Coding Type of Seizure, Seizure Frequency, and Condition Impact

Example 1: This shows the coding for a person who has a history of Juvenile Myoclonic epilepsy, which has been controlled with anticonvulsant medication for 18 months. The condition impact is considered to be mild.

Completing the CDER Form for Example 1:

Type of Seizure

27a. |9 | **28a.** | | **29a.** | |

0 Does not have seizure disorder years
1 Partial, Simple
2 Partial, Complex
4 Generalized, Absence (Petit Mal)
6 Generalized, Infantile Spasms
7 Generalized, Tonic-Clonic (Grand Mal)
9 Other/Unclassified Seizures

Seizure Frequency

27b. |2 | **28b.** | | **29b.** | |

1 History of seizures, none in two
2 History of seizures, none in one year
3 One to six per year
4 Seven to 11 per year
5 One per month (approximate)
6 One per week (approximate)
7 One per day (approximate)
8 More than one per day
9 Frequency Undetermined

27c. **|1| Condition Impact**

28c. | | Condition Impact

29c. | | Condition Impact

Note: In this example, the ICD-10 code for Juvenile Myoclonic Epilepsy (G253) should be entered in the Etiology field as shown below:

ICD-10 Code

30a. |G253 |

30b. | |

Example 2: This shows the coding for a person who has Generalized, Absence (Petit Mal) seizures approximately once a week with a mild condition impact and Generalized, *Tonic-Clonic* (Grand Mal) seizures at least 14 times per year with a moderate condition impact.

Completing the CDER Form for Example 2:

Type of Seizure
27a. | 4 | **28a.** | 7 | **29a.** | |

0 Does not have seizure disorder
1 Partial, Simple
2 Partial, Complex
4 Generalized, Absence (Petit Mal)
6 Generalized, Infantile Spasms
7 Generalized, Tonic-Clonic (Grand Mal)
9 Other/Unclassified Seizures

Seizure Frequency
27b. | 6 | **28b.** | 5 | **29b.** | |

1 History of seizures, none in two years
2 History of seizures, none in one year
3 One to six per year
4 Seven to 11 per year
5 One per month (approximate)
6 One per week (approximate)
7 One per day (approximate)
8 More than one per day
9 Frequency Undetermined

27c. |1| Condition Impact

28c. |2| Condition Impact

29c. | | Condition Impact

References

Commission on Classification and Terminology of the International League Against Epilepsy. (1989). Proposal for revised classification of epilepsies and epileptic syndromes. Epilepsia, 30, 389-399.

OTHER DEVELOPMENTAL DISABILITY

This section is for identifying and recording developmental disabilities other than those attributable to mental retardation, cerebral palsy, epilepsy or autism. "Other" developmental disabilities are disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation. It does not include handicapping conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature. Examples of conditions that could be included in this section are intracranial neoplasms, degenerative brain disease, spina bifida, etc., resulting in substantial handicap.

33, 33a, 33b. TYPE OF OTHER DEVELOPMENTAL DISABILITY
Items 33, 33a and 33b are to be used to record the type(s) of disability(ies).

Completing the CDER Form for Items 33 and 33a - 33b : Type of Other Developmental Disability

Complete Items 33, and 33a - 33b as follows:

- If the consumer does not have a related disability, check the “No” box in Item 33 and leave Items 33a - 33b and Items 34a - 34b blank.
- If the consumer does have a related disability, check the “Yes” box in Item 33 and complete Items 33a-33b. Using ICD-10 codes, enter the code for the particular disability in Item 33a. If the client has more than one disability, record the second one in Item 33b using ICD-10 codes.

NOTE: If the "hard copy" of this form is to be placed in the client's chart, you may want to write the name of the disability in the "specify" space provided.

Example of Coding Other Type of Developmental Disability

Example 1: This example shows the coding for a consumer who has another disorder that affects psychological development.

33. Other Disability: Yes ☒ No ☐

	Type of Other Disability (specify)	(ICD-10)
33a.	Other disorders of psychological development	|F88 |
33b.	_____	|_____|

34a and 34b. ETIOLOGY OF OTHER DEVELOPMENTAL DISABILITY

These items refer to any causal or contributing factors associated with the conditions codes in items 33a and 33b.

When coding etiology of Other Developmental Disabilities:

- If the client does not have such a disability, leave the item blank.
- If the client has such a disability, enter any additional contributing factor associated with the disability, using ICD-10 codes, in Item 34a.
- If the client has two such disabilities, as indicated by entries in both Item 33a and Item 33b, enter any contributing or associated factor for the second disability in Item 34b.
- If the client has such a disability but the secondary contributing factor(s) is not known, enter "0" in Item 34a and/or Item 34b.

Example of Coding Etiology of Other DD on the CDER Form

Example 1: This example shows the coding for a consumer who has cervical spina bifida with hydrocephalus and with a secondary condition of H. Influenzae meningitis.

Etiology of Other Developmental Disability

	ICD-10 Code
34a. (Cervical Spina bifida with hydrocephalus)	|Q050 |
34b. (H. influenzae meningitis)	|G000 |

Risk Factors

The purpose of these items is to record any risk factors or conditions associated with any of the client's developmental disabilities. Used in conjunction with the ICD-10 codes discussed above, they provide more precise information regarding the possible causes of the client's disabilities. Such information will be useful in planning prevention activities.

As was mentioned in earlier portions of the manual, the risk factors may be associated with any of the client's developmental disabilities. If the client has more than one specific disability, answer the Risk Factor items for all of the client's disabilities.

Indicate whether each of the following factors was associated with the client's developmental disabilities, as specified above. Code "1" for Yes if there are reasonable data to suggest the disability was associated with or significantly impacted by the factor. Code "2" for No if the factor does not pertain to the disability and Code "9" for an unknown association.

Please place a code number in the space provided next to Risk Factor items 35 through 47. LEAVE ITEMS 48 AND 49 BLANK.

1 = Yes 2 = No 9 = Unknown

35. |___| Low birth weight or preterm labor with complications
36. |___| Teenage pregnancy (17 years and younger)
37. |___| Maternal age 35 years or older at time of delivery
38. |___| Accidents of near drowning
39. |___| Accidents involving an automobile
40. |___| Accidents involving other types of vehicles
41. |___| Accidents of other types
42. |___| Environmental toxins (pesticides, lead, etc.,)
43. |___| Drug or alcohol abuse
44. |___| Psychosocial (environmental) deprivation
45. |___| Family history of mental retardation
46. |___| Child abuse or neglect
47. |___| Other cause(s)
48. |___|
49. |___|

Example of Coding Risk Factors

This example shows the coding for a client who is mentally retarded and who has a seizure disorder, both etiologically connected to Hemophilus meningitis (ICD-10 coding under etiology above as G000 in 30a). In addition, the client was born to a family with a history of Mental Retardation (Risk Factor Item 45), and was premature and of low birth weight (Risk Factor Item 35).

Example 1 coding Risk Factors:
<u>Risk Factor</u> (for use in etiology items 12a-b, 18a-b, 24a-b, 30a-b and 34a-b).

1 = Yes 2 = No 9 = Unknown

35. |_1_| Low birth weight or preterm labor with complications
36. |_2_| Teenage pregnancy (17 years and younger)
37. |_2_| Maternal age 35 years or older at time of delivery
38. |_2_| Accidents of near drowning
39. |_2_| Accidents involving an automobile
40. |_2_| Accidents involving other types of vehicles
41. |_2_| Accidents of other types
42. |_2_| Environmental toxins (pesticides, lead, etc.)
43. |_2_| Drug or alcohol abuse
44. |_2_| Psychosocial (environmental) deprivation
45. |_1_| Family history of mental retardation
46. |_2_| Child abuse or neglect
47. |_9_| Other cause(s)
48. |___|
49. |___|

PSYCHIATRIC DISORDERS

The items in this section indicate whether or not the consumer has a psychiatric disorder in addition to a developmental disability. A psychiatric disorder is a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual, which is associated with present distress (e.g., a painful symptom), disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever the original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts primarily between the individual and society are psychiatric disorders, unless the deviance or conflict is a symptom of dysfunction in the individual, as described above.

Complete this section only if a diagnosis of a psychiatric disorder has been made by a psychologist, psychiatrist, or by other qualified persons trained to diagnose psychiatric disorders (e.g., physicians, Licensed Clinical Social Workers).

Although Autistic Disorder, Asperger Disorder, and Pervasive Developmental Disorder, NOS, are classified as psychiatric disorders, these disorders should not be coded here. If the consumer has a diagnosis of Autistic Disorder, Asperger Disorder, or Pervasive Developmental Disorder NOS, it should be addressed in the Autistic Disorder section rather than here. Likewise, Rett Syndrome and Childhood Disintegrative Disorder are not recorded in this section. Instead, these disorders are to be recorded under the Mental Retardation and Epilepsy Sections as appropriate.

50a, 51a, 52a, 53a. TYPE OF PSYCHIATRIC DISORDER

These items indicate the types of psychiatric disorders the consumer may have, as set forth in Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR).

Information for consumers with a developmental disability and a psychiatric disorder (“dual diagnosis”) is to be recorded in both the applicable Developmental Disabilities Section and the Psychiatric Disorders Section. However, do not record consumers’ developmental disability diagnosis (e.g., mental retardation) in the Psychiatric Disorders Section. As the developmental disability information has been recorded in the Developmental Disabilities Section, only those specific psychiatric disorders that meet the criteria set forth in DSM-IV-TR are to be recorded in this section.

When rating the consumer:

- This section should be used to record psychiatric disorders only when the consumer's record indicates he or she has been evaluated by a qualified professional who has determined, in writing that the consumer has a psychiatric disorder and who has provided a diagnosis of that disorder. Undiagnosed "behavior problems" do not constitute a valid diagnosis.

- Use the diagnostic codes and names for the psychiatric disorder as specified in the DSM-IV-TR.

- Only Axis I and Axis II conditions, if applicable, are to be recorded in this section. The consumer may have disorders in both axes.

    - Axis I comprises the entire classification of psychiatric disorders as well as conditions not attributable to psychiatric disorders that are an important focus for treatment.

    - Axis II involves personality disorders and mental retardation.

- If two diagnoses are made on either Axis, code the most significant condition requiring treatment as the first diagnostic code within the Axis.

- If the diagnosis is deferred on either Axis I or Axis II, code as "799.9" *Psychiatric disorder diagnoses are not to be deferred for longer than one year.*

- If there is a diagnosis for Axis I but no Axis II diagnosis, enter the appropriate DSM-IV-TR code under Axis I and enter code "V71.09" under Axis II. Conversely, if there is an Axis II diagnosis but no Axis I diagnosis, code Axis I as "V71.09" and code the appropriate DSM-IV-TR diagnosis under Axis II. Other codes beginning with a "V" will rarely be the most appropriate code.

50b, 51b, 52b, 53b. DATE OF LAST EVALUATION

Date of Last Evaluation is the date on which the consumer was most recently assessed as having the psychiatric disorder(s) coded under items 50a—53a. If the date is unknown, or is illegible, use the pseudo date 07/03 to complete this item.

50c, 51c, 52c, 53c. CONDITION IMPACT

Condition Impact refers to the extent or degree to which the diagnosed psychiatric disorder affects the level of supervision/care required and/or the program placement of the consumer. Enter the appropriate code, as shown below, in one of the spaces provided.

Condition Impact Definitions

None: No evidence of impairment.

Mild: Condition requires some special attention when planning for the consumer's placement and/or some extra supervision/care.

Moderate: Condition has a major impact upon the ability to obtain an appropriate placement for the consumer and/or requires a considerable amount of supervision/care.

Severe: Condition is so substantial that it is exceedingly difficult to find an appropriate placement for the consumer and/or constant supervision/care is required.

Completing the CDER Form

Type of Psychiatric Disorder, Date of Last Evaluation, and Condition Impact

(Items 50a – 53a, 50b – 53b, and 50c – 53c)

Type of Psychiatric Disorder (Items 50a – 53a):

- If the consumer has a psychiatric disorder(s), enter the appropriate DSM-IV-TR code and complete the respective "b" (Date of Last Evaluation) and "c" (Condition Impact) items for the particular psychiatric disorder recorded in the "a" (Axis column). In other words, if an entry has been made in 50a and 52a, then Items 50b and 50c, and Items 52b and 52c must also be completed.

- If the consumer has no diagnosis of a psychiatric disorder, enter 07/03 in Item 50a and leave all other items in this section blank.

Date of Last Evaluation (Items 50b –53b):

- If the consumer has no psychiatric disorder, this item should be left blank.

- If the consumer has a psychiatric disorder but the date is not in the consumer's records, or is otherwise not available, enter the pseudo-date of 07/03.

Condition Impact (Items 50c – 53c):

Enter the appropriate code, based on the above definitions, in Items 50c, 51c, 52c and 53c as applicable. The codes are as follows:

Condition Impact Codes:

3 No Evidence of Impairment
4 Mild
5 Moderate
6 Severe

When Coding Condition Impact:

- If the consumer has no psychiatric disorder, these items should be left blank.

- If the consumer has a psychiatric disorder, but it does not have an affect upon supervision/care and/or program placement, enter code "0" ("No Evidence of Impairment").

(See examples below for completing Type of Psychiatric Disorder, Date of Last Evaluation and Condition Impact)

Examples of Coding Type of Psychiatric Disorder, Date of Last Evaluation, and Condition Impact

Example 1: Following is an example of coding for a person with an adjustment disorder with mixed anxiety and depressed mood where a moderate level of supervision is necessary. Additionally, the person has a personality disorder, not otherwise specified, with minimal impact to the amount of supervision required. The date of last evaluation for the diagnoses on both axes is January 1, 2004.

Completing the CDER Form Example 1

Type of Psychiatric Disorder

Axis I	Date of Last Evaluation	Condition Impact
50a. | 3 | 0 | 9 |.| | |	**50b.** | 0 | 1 | 0 |1 | 0 | 4 |	**50c.** | 2 |
51a. | | | |.| | |	**51b.** | | | | | | |	**51c.** | |
52a. | 3 | 0 | 1 |.| 9 | |	**52b.** | 0 | 1 | 0 | 1 | 0 | 4 |	**52c.** | 1 |
53a. | | | |.| | |	**53b.** | | | | | | |	**53c.** | |

Example 2: This example represents a consumer with the same personality disorder as the one above where minimal supervision is required, but he/she does not have a psychiatric disorder under Axis I. The date of last evaluation for the Axis II diagnosis is January 1, 2004.

Completing the CDER Form Example 2

Type of Psychiatric Disorder

Axis I	Date of Last Evaluation	Condition Impact
50a. | V | 7 | 1 |.| 0 | 9 |	**50b.** | 0 | 1 | 0 | 1| 0 | 4 |	**50c.** |2 |
51a. | | | |.| | |	**51b.** | | | | | | |	**51c.** | |
52a. | 3 | 0 | 1 |.| 9 | |	**52b.** | 0 | 1 | 0 | 1 | 0 | 4 |	**52c.** | 1 |
53a. | | | |.| | |	**53b.** | | | | | | |	**53c.** | |

Example 3: This example involves a person with an obsessive-compulsive disorder with moderate condition impact and a bipolar disorder with mild condition impact. The records show this consumer was diagnosed as having borderline and paranoid personality disorders, both having an impact requiring moderate supervision. The date of last evaluation for the diagnoses on both axes is January 1, 2004.

Completing the CDER Form Example 3:

Type of Psychiatric Disorder

Axis I	Date of Last Evaluation	Condition Impact
50a. | 3 | 0 | 0 |.| 3 | |	**50b.** | 0 | 1 | 0 | 1 | 0 | 4 |	**50c.** | 2 |
51a. | 2 | 9 | 6 |.| 8 | |	**51b.** | 0 | 1 | 0 | 1 | 0 | 4 |	**51c.** | 1 |
52a. | 3 | 0 | 1 |.| 8 | 3 |	**52b.**| 0 | 1 | 0 | 1 | 0 |4|	**52c.**| 2 |
53a. | 3 | 0 | 1 |.| 0 | |	**53b.** | 0 | 1 | 0 | 1 | 0 | 4 |	**53c.** | 2 |

CHRONIC MAJOR MEDICAL CONDITION

These items indicate the presence of major, chronic medical problems that limit or impede the client or significantly impact the provision of service. Using ICD-9 code(s), specifically list the client's significant medical condition(s). Do not list the AAIDD diagnoses, the DSM-IV-TR diagnoses, nor the causes of Mental Retardation, for example, phenylketonuria. Do not list acute, self-limiting illnesses (such as pneumonia, measles, etc.), nor any static nonlimiting condition (such as acne). List only those major conditions that are chronic and require continued medical follow-up or treatment and have a significant impact on the client's functioning. Such conditions include, but are not limited to, diabetes mellitus, hypertension, congenital or arteriosclerotic heart disease, upper respiratory infections, etc.

55a – 59a. TYPE OF CHRONIC MAJOR MEDICAL CONDITIONS

Because of the significant impact of chronic hepatitis or the presence of its carrier state, the following **hepatitis coding should be included among the client's Major Medical Conditions.** Please use the following ICD-9 codes to indicate immune status for Hepatitis B:

070.0	Viral Hepatitis B
070.30	Hepatitis B susceptible
070.31	Hepatitis B immune
070.32	Hepatitis B carrier
070.33	Hepatitis B vaccination in progress
070.34	Hepatitis B immune status unknown

When coding Condition Type:

- Enter the appropriate ICD-9 code as listed above for Hepatitis in Item 54a.

- Enter ICD-9 codes in items 55a through 59b, using as many items as necessary, to record the client's Major Medical Condition(s) other than Hepatitis.

- If the "hard copy" of the CDER form is to be retained in the client's record and if it is desired, write the name of the condition in the "specify" space provided.

- If the client has no major medical condition, enter 000.00 in Item 55a and leave all other items in this section (including Condition Impact items) blank.

Examples of Coding Types of Chronic Major Medical Conditions

Example 1: Client who is a carrier of Hepatitis B

Condition Type(s) Specify		Condition ICD-9 Code	Condition Impact	
54a.	Hepatitis B Carrier	|0|7|0|.|3|2|	54b.	| |
55a.	_____	| | | |.| | |	55.b	| |
56a.	_____	| | | |.| | |	56b.	| |

Example 2.: Client with two major chronic medical conditions, who is a carrier of Hepatitis B

Condition Type(s) Specify		Condition ICD-9 Code	Condition Impact	
54a.	Hepatitis B Carrier	|0|7|0|.|3|2|	54b.	| |
55a.	Hypertension (benign)	|4|0|1|.|1| |	55b.	| |
56a.	Atherosclerosis (of Aorta)	|4|4|0|.|0| |	56b.	| |

54b.-59b. CONDITION IMPACT

This refers to the extent or degree to which the major chronic medical condition(s) affects the level of supervision/care required for and/or program placement of the individual.

Enter one of the appropriate codes as listed below in the spaces provided.

Condition Impact

0 No evidence of impairment
1 Mild . . . . . Condition requires some special attention when planning for the client's placement and/or some extra supervision/care
2 Moderate . . .Condition has a major impact upon the ability to obtain an appropriate placement for the client and/or requires a considerable amount of supervision/care
3 Severe . . . . .Condition is so substantial that it is exceedingly difficult to find an appropriate placement for the client and/or constant supervision/care is required.

- If the client has no chronic medical condition, leave these Items 54b-59b blank.

- If the client has a chronic medical condition, but this condition does not affect level of supervision required and/or program placement, code the client "0" – "No evidence of impairment."

- If the client has a major medical condition, enter the code which represents the degree of impact on supervision/care and/or placement.

Example of Coding Condition for Chronic Major Medical Condition

Example 1: This is an example of coding a client whose hypertension requires some special attention (mild impact) and whose heart disease requires a considerable amount of care (moderate impact). Hepatitis status has no impact (See Example 2 above).

Condition Impact

54b. |0|
55b. |1|
56b. |2|
57b. | |
58b. | |
59b. | |

HEARING

60. LEVEL OF HEARING LOSS UNCORRECTED

Items 60-61 are concerned with the client's hearing, first without the use of corrective measures and then with the use of corrective measures, if they are necessary. The purpose of recording the client's hearing before and after correction is to determine if it can be improved, as this can be a factor in placement and/or level of supervision/care required. Code the uncorrected level of hearing loss in Item 60; code the level of hearing loss after corrective measures have been made in Item 61.

The rating levels in this item indicate the client's hearing capabilities. Ideally, hearing should be tested relative to the client's ability to hear under everyday conditions. If the client requires a hearing aid, he/she is to be tested and rated first without the hearing aid.

The codes below represent the client's hearing capability without correction.

Level of Hearing Loss Uncorrected

0 Hearing within normal limits
1 Mild to moderate hearing loss (hard of hearing)
2 Severe hearing loss
3 Profound hearing loss
4 Hearing loss, one ear
9 Hearing loss suspected, severity undetermined

Note: Rate at Level "4" – Hearing loss, one ear – the client who has severe or worse hearing loss in one ear and hearing within normal limits in the other ear. If the client has partial hearing loss (moderate or better) in one ear, and hearing within normal limits in the other ear, rate the client's overall level of hearing loss; do not rate at Level "4" in this case.

61. LEVEL OF HEARING LOSS CORRECTED

This item refers to the client's hearing capability after being corrected with the use of a hearing aid. The codes below represent the client's hearing capability after being corrected with a hearing aid.

The codes below represent the client's hearing capability after being corrected with a hearing aid.

Level of Hearing Loss Codes Corrected

0 Hearing within normal limits
1 Mild to moderate hearing loss

2 Severe hearing loss
3 Profound hearing loss
8 Correction not possible (because of medical or other reasons)
9 Hearing loss not corrected

When rating the client's hearing:

- If the client's hearing has been corrected and he/she wears the hearing aid more than 50 percent of the time, rate the Client while wearing the hearing aid at the appropriate level "0" – "3".

- If, for any reason, it is not possible to correct the client's hearing, for example, hearing is not correctable due to medical reasons, or the client's behavior (such as constant bumping of head) precludes the wearing of a hearing aid, rate the client at Level "8" – Correction not possible.

- If the client's hearing loss is not corrected or he/she does not wear a hearing aid most of the time, rate at Level "9".

Example of Coding Level of Hearing Loss

Example 1: Following is an example of coding for a client with severe hearing loss (uncorrected) in one ear and hearing within normal limits in the other ear; and the same client whose hearing has been corrected, and as a result, hearing improved to moderate hearing loss in one ear and hearing within normal limits in the other ear.

Level of Hearing Loss Uncorrected

60. |4|

0 Hearing within normal limits
1 Mild to moderate hearing loss (hard of hearing)
2 Severe hearing loss
3 Profound hearing loss
4 Hearing loss, one ear
9 Hearing loss suspected, severity undetermined

Level of Hearing Loss Corrected

61. |1|

0 Hearing within normal limits
1 Mild to moderate hearing loss
2 Severe hearing loss
3 Profound hearing loss
8 Correction not possible
9 Hearing loss not corrected

VISION

62. LEVEL OF VISION LOSS UNCORRECTED

The rating levels in these items indicate the degree of the client's visual impairment without glasses or contact lenses. It refers to a functional limitation of the eye (for example, limited visual acuity or visual field) and should be distinguished from visual disability (such as limited reading skills). If the client requires glasses or contact lenses, he/she is to be tested first without them.

The purpose of rating the client's vision before and after correction is to determine if visual acuity can be improved, as visual impairment can affect supervision/care of the placement of the client.

If tests other than those that measure acuity are used, then the results are to be transferred into acuity levels of measurement.

The codes below represent the various levels of vision impairment without corrective aids.

Level of Vision Loss Codes (Uncorrected)	**Acuity**
0	Vision within normal limits……..20/12 to 20/30
1	Mild impairment…….20/31 to 20/70
2	Moderate impairment……20/71 to 20/200
3	Severe impairment (legally blind)……Greater than 20/200
4	Total blindness……No light perception Must rely on other senses entirely.
5	Vision loss, one eye……Greater than 20/200 Indicates severe impairment or worse in one eye and vision within normal limits in the other eye.
9	Vision loss suspected, severity not determined. Indicates vision impairment is evident but the client has not been tested.

When coding the client's level of vision loss uncorrected:

- If vision has been tested (without corrective lenses) and the results have been reported in the client's record, enter the appropriate code (levels "0" – "5") as listed above, in box 62.

- If vision impairment is evident but there is no record of testing, rate the client at Level "9."

NOTE: Rate at Level "5" – Vision loss, one eye – the client who has severe or worse vision loss (acuity greater than 20/200 in one eye and vision within normal limits in the other eye. If the client has partial vision loss (moderate or better) in one eye, and vision within normal limits in the other eye, rate the client's overall level of vision loss: do not rate at Level "5" in this case.

Refer below for an example coding this item.

63. LEVEL OF VISION LOSS CORRECTED

Item 63 refers to the client's level of vision after being corrected with glasses or contacts. If the client's vision is corrected and he/she wears the corrective lenses more than 50 percent of the time, rate the client wearing them at the appropriate level **"0"**-"3".

The codes below represent the client's level of vision after it has been corrected.

Level of Vision Loss Codes (Corrected)

0	Vision within normal limits
1	Mild impairment
2	Moderate impairment
3	Severe impairment
8	Correction not possible
9	Vision not corrected

When coding the client's level of vision loss corrected:

- If, for any reason, correction is not possible, for example, medical reasons or client's behavior precludes the use of corrective lenses, rate at Level "8".

- If the client's vision uncorrected is within normal limits-code **"0"** in Item 62, leave this item (63) blank.

- If the client's vision impairment is not corrected or he/she does not wear glasses or contacts most of the time, rate at Level "9".

Examples of Coding Level of Vision Loss

Example 1. The example below shows coding for a client whose uncorrected vision in one eye is severely impaired and is mildly impaired in the other eye; after correction with glasses the level of vision impairment in one eye is moderate and in the other eye is mild.

Level of Vision Loss Uncorrected

62. |3|
- 0 No vision loss
- 1 Near normal
- 2 Moderate impairment
- 3 Severe impairment (legally blind)
- 4 Total blindness (no light perception)
- 5 Vision loss, one eye
- 9 Vision loss suspected, severity undetermined

Level of Vision Loss Corrected

63. |1|
- 0 Vision within normal limits
- 1 Mild impairment
- 2 Severe vision loss
- 3 Profound vision loss
- 8 Correction not possible
- 9 Vision loss not corrected

Example 2. This example is of a client whose uncorrected level of vision loss is severe and whose corrected vision loss is still severe.

Level of Vision Loss Uncorrected

62. |3|
- 0 No vision loss
- 1 Near normal
- 2 Moderate impairment
- 3 Severe impairment
- 4 Total blindness
- 5 Vision loss, one eye
- 9 Vision loss suspected, severity undetermined

Level of Vision Loss Corrected

63. |2|
- 0 Vision within normal limits
- 1 Mild to moderate vision loss
- 2 Severe vision loss
- 3 Profound vision loss
- 8 Correction not possible
- 9 Vision loss not corrected

PSYCHIATRIC/BEHAVIOR MANAGEMENT MEDICATION

64.-69. TYPE(S) OF PRESCRIBED MEDICATION FOR BEHAVIOR AND/OR PSYCHIATRIC MANAGEMENT

The purpose of these items is to determine if the client is receiving medication specifically prescribed to control challenging behavior/psychiatric symptoms. Examples of challenging behavior include hyperactivity, self-injurious behavior, aggression, and poor impulse control. Also included are behaviors or symptoms associated with psychiatric diagnoses; for example, behaviors associated with thought disorders, hallucinations, depression, mania, severe mood swings, or anxiety would be included. **Medications that result in the control of challenging behavior, but are prescribed for other purposes, should not be included here.**

Enter code "1" = Yes or "2" = No for each of the following types of medications.

Type(s) of Prescribed Medication for Challenging Behavior and/or Psychiatric Management

64. Antipsychotic
65. Antidepressant
66. Anti-anxiety
67. Sedative/Hypnotic
68. Stimulant
69. Other Psychotropic Drug

If a drug that the client is taking to control challenging behavior and/or psychiatric symptoms does not fit into any of the types given, code Item 69, Other Psychotropic Drug, "1" for Yes. **Item 69 should only be used for psychotropic drugs that cannot be categorized under items 64-68.**

For "combination" drugs, code all parts of the combination separately in the appropriate category type; for example, Limbitrol (Amitripyline and Chlordiazepoxide) would be coded "1: = Yes in Items 65 (antidepressant) and 66 (anti-anxiety).

Note that in situations where the client has "paradoxical response" to a certain medication, rate the client according to the formulary – in other words, its original purpose. For example, if a sedative type of medication has a stimulating (opposite) effect on a client, the medication would still be designated as a sedative medication; therefore enter Code "1" in Item 67.

Example of Coding Types of Prescribed Medication for Challenging Behavior and/or Psychiatric Management

Example 1: This client has been prescribed Haldol and Valium to control challenging behavior. Haldol is an antipsychotic and Valium is an anti-anxiety medication.

Example 1: **Types of Prescribed Medication for Challenging Behavior and/or Psychiatric Management**

1 = Yes 2 = No

64. |1| Antipsychotic
65. |2| Antidepressant
66. |1| Anti-anxiety
67. |2| Sedative/Hypnotic
68. |2| Stimulant
69. |2| Other Psychotropic Drug

70. HISTORY OF PRESCRIBED MEDICATION FOR CHALLENGING BEHAVIOR AND/OR PSYCHIATRIC MANAGEMENT

This item is concerned with the present and past status on the client's medication treatment for challenging behavior and/or psychiatric management (see definition given with the preceding item). Enter in Item 70 the appropriate code "1" - "5" if the client has or has had a prescription for a drug that is or has been used continuously. "Continuously" means used daily for more than a month or on some other regular basis, such as a long-acting drug given intramuscularly on a weekly or biweekly basis. "Continuously" does not include occasionally, such as for dental work. If there is no known information that the client has received medication for challenging behavior and/or psychiatric management, use code "6".

The medications of interest in this item are listed in the previous item and are categorized as antipsychotic, antidepressant, anti-anxiety, sedative/hypnotic, and stimulant.

The codes below represent the status of the client's history of medication taken continuously for the purpose of controlling challenging behavior and/or psychiatric symptoms.

History of Prescribed Medication for Challenging Behavior and/or Psychiatric Management Codes

1 Currently receiving one or more prescribed medication(s)
2 Medication(s) discontinued within six months
3 Medication(s) discontinued more than six months but less than one year
4 Medication(s) discontinued more than one year but less than four years
5 Has not received medication(s) during past four years
6 No known documented history of receiving medication(s)

Example of Coding History of Prescribed Medication for Challenging Behavior and/or Psychiatric Management

Example 1. The example below shows the coding for a client who has taken medication to control challenging behavior and/or psychiatric symptoms but has not taken any in the past three months.

History of Prescribed Medication for Challenging Behavior and/or Psychiatric Management

70. |2|

1 Currently receiving one or more prescribed medication(s)
2 Medication(s) discontinued within six months
3 Medication(s) discontinued more than six months but less than one year
4 Medication(s) discontinued more than one year but less than four years
5 Has not received medication(s) during past four years
6 No know documented history of receiving medication(s)

Example 2. The example below shows the coding for a client who (in the past) has taken medication prescribed to control challenging behavior and/or psychiatric symptoms, but has been off for two and one-half years.

History of Prescribed Medication for Challenging Behavior and/or Psychiatric Management

70. |4|

1 Currently receiving one or more prescribed medication(s)
2 Medication(s) discontinued within six months
3 Medication(s) discontinued more than six months but less than one year
4 Medication(s) discontinues more than one year but less than four years
5 Has not received medication(s) during past four years
6 No known documented history of receiving medication(s)

ABNORMAL INVOLUNTARY MOVEMENTS

71. -75. TYPE(S) OF INVOLUNTARY MOVEMENT(S)

THESE ITEMS ARE TO BE COMPLETED FOR DEVELOPMENTAL CENTER CLIENTS ONLY.

Involuntary movements may be caused by inherited or acquired factors. However, in rating the items no etiology is implied. There are many types of involuntary movements, but only five types have been distinguished for classification here. The client's physician is responsible for assuring the accuracy of the ratings. These items may only be completed or based on information given by a person specifically trained to recognize these movements. Each of the following items should be coded "1" = Yes if the movement is present or "2" = No if the movement is not present. A movement need not be persistent to be coded "1". It should be coded "1" even if it does not occur often.

Following are definitions of the movements of concern:

71. Parkinsonism is a constellation of symptoms characterized by abnormal slowness, diminished spontaneity and associative movements, rigidity, and resting tremor. Typical symptoms include: bradykinesia, diminished arm swing, small steps, rigidity, cogwheeling, masked face (diminished spontaneous facial expression), sialorrhea (drooling), seborrhea (greasy skin), resting tremors, micrographia, postural instability, stooped posture, turning "en bloc," hypotonia, positive glabellar response, and diminished rate of blinking.

72. Dystonia is persistent deviation of a body part due to abnormal muscle contraction. Partial or incomplete dystonia may consist of a tendency to abnormal deviation, which can be overcome (at least temporarily) by volitional corrections; repetitious movements may result from this interaction between voluntary and involuntary movements. Examples of Dystonia movements include: oculat (e.g., retrocollis, torticollis), limb deviation, and trunk deviation. Hypertonia need not be part of the deviation.

73. Dyskinesia is involuntary choreoathetoid movements which may appear to be semi purposeful (cf. rhythmic or explosive). The name "Athetosis" refers to a slow, torsional movement.

74. Akathisia (or Acathisia) is motor restlessness. Symptoms include shifting of position while standing, alternate sitting and standing, rocking, and inappropriate pacing. Akathisia is different from "hyperactivity," which is less rhythmetic.

75. Paroxysmal is abrupt, non purposeful movement of body parts (e.g., tics, twitches, which are not part of a convulsive seizure).

Example of Coding Abnormal Involuntary Movements

Example 1: Following is an example of coding a developmental center resident who persistently experiences Parkinsonism. The reason he/she has the movement disorder is of no concern here, i.e., the client could have inherited the disorder or acquired it through prolonged use of any type of psychotropic drug.

Types of Involuntary Movements
1 = Yes 2 = No

71. |1|
72. |2|
73. |2|
74. |2|
75. |2|

SPECIAL HEALTH CARE REQUIREMENTS

76. – 85. SPECIAL HEALTH CARE REQUIREMENTS

The purpose of this section is to determine if the client has any special requirements(s) due to a chronic long-term condition and to identify such requirement(s). Special health care requirements refer only to those medications, treatments, equipment, etc., which represent normal, routine procedures. Do not code medications, treatments, equipment, etc., that are necessary for nonchronic, short-term conditions.

- If the client does not have such a requirement, enter “00” in Item 76 and leave Items 77-85 blank.

- If the client has a special health care requirement, enter the appropriate two-digit code as listed on the following pages.

- As many as ten special health care requirements may be entered. If the client has more than ten, enter the ten most significant requirements.

- As many as ten special health care requirements may be entered. If the client has more than ten, enter the ten most significant requirements.

- If the client has more than one special requirement one year, but in the following year no longer has one or more of these requirements, in the new year re-enter the remaining requirements, beginning with Item 76. In other words, move the requirements forward so that there will not be blank spaces before or between the requirements.

Examples of Coding Special Health Care Requirements

Example 1. Client has an ileostomy (code 21), is on a special diet (code 42), and needs to use a walker (code 55) for ambulation.

76.	|2|1|	77.	|4|2|	78.	|5|5|	79.	| | |	80.	| | |
81.	| | |	82.	| | |	83.	| | |	84.	| | |	85.	| | |

Example 2. Client requires decubitus care (code 64), frequent turning in bed (code 65), a gastrostomy tube (code 43), and an indwelling catheter (code 22).

76.	|2|2|	77.	|4|3|	78.	|6|4|	79.	|6|5|	80.	| | |
81.	| | |	82.	| | |	83.	| | |	84.	| | |	85.	| | |

Following is the list of and definitions for Special Health Care Requirements.

SPECIAL HEALTH CARE REQUIREMENTS

(Refer to Items 76-85)

Health Care Requirement	Code
I. SPECIAL TREATMENT/TESTING NEEDS	
Sterile Dressings A procedure where, in a sterile environment, dressings are changed for a chronic condition on a daily basis.	1 1
Diabetic Test The client is diagnosed as being diabetic and requires daily testing.	1 2
Diabetic or Other Injections The client has a medical condition that requires at least weekly injections.	1 3
Other	1 4
II. ELIMINATION NEEDS	
Ostomy Equipment The client has a colostomy or ileostomy and requires direct care and treatment by another person (including changing colostomy bag, application of dressing, and irrigations). The client may be able to perform some of the tasks, but requires close supervision.	2 1

Catheter 2 2
The client has a condition that necessitates the use of either an indwelling or external catheter on daily basis.

Enemas 2 3
The client requires regularly prescribed enemas on an ongoing basis.

Other 2 4

III. RESPIRATORY NEEDS

Apnea Monitor 3 1
The client is diagnosed as having panic spells that require the use of an apnea monitor.

Tracheostomy Care 3 2
The client presently has a tracheostomy, including relevant suctioning care.

Suctioning 3 3
The client's respiratory condition is such that he/she requires suctioning on a daily basis. Do not include suctioning required by tracheostomy.

Inhalation Therapy 3 4
The client requires inhalation therapy three times a week or more.

Oxygen 3 5
The client requires oxygen assistance more than once a week.

Respirator 3 6
The client needs mechanical assistance to maintain adequate ventilation.

Other 3 7

IV. EATING NEEDS

Special Eating Utensils 4 1
The client requires special cups, plates, spoons, knives, forks, etc., to feed self.

Special Diet 4 2
Client requires modified consistency diet (inclusive) other than that which is routinely provided in the home for example; diabetic, PKU, Prader-Willi, low sodium and other endocrine, and metabolic deficiencies.

Nasal/Gastric Tube or Gastronomy 4 3
The client requires all dietary needs via nasal/gastric tube or gastrostomy tube, or oral feedings are supplemented with nasal/gastric tube or gastrostomy tube feedings.

Parenteral Equipment 4 4
The client requires parenteral (intravenous or other) feedings to augment existing diet or as a primary source of nutrition.

Other 4 5

V. MOBILITY NEEDS

Prosthetic Device (limb, hand, etc.) 5 1
The client requires a prosthetic device, such as an artificial limb, hand, etc., to ambulate or complete activities of daily living.

Electric Wheelchair 5 2
The client uses an electric wheelchair

Manual Wheelchair 5 3
The client uses a manual wheelchair

Special Chair 5 4
The client uses a specially designed chair for positioning purposes

Walker 5 5
The client needs the assistance of a walker for ambulation.

Braces/Splints/Casts/Orthopedic Shoes 5 6
Client wears braces, splints, casts, or orthopedic shoes on a daily basis to prevent contractures and aid in ambulation.

Crutches/Cane 5 6
The client uses a cane and/or crutch.

Other 5 8

VI. ADAPTIVE POSITIONING NEEDS

Special Bed 6 1
The client's medical needs are such that they require other than the standard bed.

Floatation Cushion/Pad 6 2
The client requires a floatation cushion or pad, or similar device.

Belly Board 6 3
The client has to be place on a belly board as part of daily program.

Decubitus Care and Equipment 6 4
The client has decubiti and requires frequent turning, medical treatment and/or special mattresses.

Frequent Turning in Bed 6 5
The client is unable to reposition self, and requires frequent repositioning.

Head Protective Device 6 6
The client has to wear a helmet or similar protective device as part of a daily program.

Other 6 7

VII. OTHER HEALTH REQUIREMENTS NOT LISTED ABOVE 7 1

SPECIAL CONDITIONS OR BEHAVIORS

Items in this section are optional. Please rate them only when it is necessary to know this information for rate-setting and placement decisions.

The purpose of this section is to determine if the client has a condition or behavior that may affect placement in a suitable living arrangement or day program. Items in this section are meant to act as flags to alert those persons responsible for placement to certain conditions or behaviors the client may have that could make finding a living arrangement or participating in a program difficult. Additionally, items in this section are not meant to duplicate items already in the Evaluation Element of CDER.

86.-94. SPECIAL CONDITIONS OR BEHAVIORS (OPTIONAL)

Items 86-94 are specific conditions and behaviors of concern that may preclude or make difficult the placement of the client. Make an entry, 1 = Yes, 2 = No, or 3 = Unknown for each behavior/condition.

Please use the code 1 = Yes only when documents or other data indicate the existence of the given condition or behavior. If the answer to a particular item is unknown, please code 3 = Unknown.

Following are definitions of the special conditions or behaviors.

DEFINITIONS OF SPECIAL CONDITIONS OR BEHAVIORS

86. Does the client display inappropriate sexual behavior?

This item should be answered “yes” if the client manifests any of the following:

Use of inappropriate sex object
Inappropriate touching of self
Sexual fixation
Masturbation in public
Displaying genitals in public
Assaultive behavior of a sexual nature against minors
Assaultive behavior of a sexual nature against adults

87. Has the client engaged in any assaultive behaviors that have or could have resulted in serious bodily injury or death?

This item should be answered “yes” if the client has committed or attempted to commit homicide (including murder, voluntary or involuntary manslaughter), robbery, or felonious assault.

88. Has the client attempted suicide in the past five years?

This item should be answered “yes” if the client has attempted suicide in the past five years.

89. Does the client habitually engage in theft?

This item should be answered “yes” if the client has habitually engaged in stealing, either in the community or in the living arrangement during the past five years. Note the concern here is regarding those persons who are aware of what they are doing – they know the act they are committing is taking that which does not belong to them.

90. Has the client participated in acts of vandalism or other acts of property destruction?

This item should be answered “yes” if the client has engaged in acts of vandalism or similar acts of property destruction, such as breaking windows, furniture, etc., during the past five years.

91. Has the client been convicted of any substance – or alcohol abuse related offenses?

This item should be answered “yes” if the client has been convicted of any substance-abuse or alcohol-abuse related offenses, such as selling or possession of controlled substances, during the past five years.

92. Does the client have a recent history of abusing drugs or alcohol?

This item should be answered “yes” if the client is currently abusing or has within the past three years abused drugs or alcohol.

93. Does the client have a recent history of habitual lying?

This item should be answered “yes” if the client habitually lies and thereby creates problems, or has created problems in his or her program or living arrangement during the past three years.

94. Does the client display behaviors which could result or have resulted in fire setting?

This item should be answered “yes” if the client has a history of setting fires or engaging in behaviors that could result in fires. Examples of such behaviors include but are not limited to: fascination with matches, lighters, and fire; collecting matches and lighting them, but setting nothing on fire; setting off false fire alarms; setting small fires to express frustration; and having the inability to resist the impulse to set fires after much preparation.

SPECIAL LEGAL CONDITIONS

This section refers to any special legal conditions pertaining to the client. Included here are probationary or parole status, diversion under Penal Code sections 1001.20 et seq., commitment under Welfare and Institutions Code section 6500, conservatorship under Lanterman-Petris-Short (LPS), conservatorship under the Probate Court, and dependent child status under Welfare and Institutions Code (W&I) section 300 et seq.

95, -100. SPECIAL LEGAL CONDITIONS

Make an entry 1 = Yes, 2 = No for each of the following items.
Complete for all clients.

95. Is the client currently on probation, county or state parole, or commitment under Penal Code or Welfare and Institutions Code sections relating to a criminal offense?

This item should be answered “yes” if the client is currently on probation, county or state parole or under commitment under (1) Penal Code Section 1367 et seq., as incompetent to stand trial, or (2) under Penal Code Section 1026, as not guilty of a criminal offense by reason of insanity, or (3) W&I Code Section 1756 as a person transferred from the Youth Authority or from Department of Corrections (PC Section 2684) to DDS for placement. The client may be placed either in a state facility or directly into the community. Additionally, these would be clients who may be returned to the community under Penal Code 1608 et seq.

96. Is the client currently on Diversion pursuant to Penal Code section 1001.20 et seq.?

This item should be answered “yes” if the client is on Diversion status. A Diversion client is a developmentally disabled person “diverted” out of the criminal justice system pursuant to Penal Code statutes relating to drug abuse and family violence. Included are developmentally disabled persons returned to the community from the Department of Corrections on parole or into a work furlough program. Many of these clients will be adults, as children are usually dealt with through the W&I Code. NOTE: these clients are usually not housed in state developmental centers.

97. Is the client currently a person within the provisions of Welfare and Institutions Code Section 6500 et seq. (i.e., dangerous individual with mental retardation committed by the Court)?

This item should be answered “yes” if the client is currently under a W&I Code Section 6500 commitment. Persons committed under this section are a

danger to self and others and are thus committed by the court to DDS for appropriate placement.

98. Is the client currently under a Lanterman, Petris, Short (LPS) (mental health) conservatorship?

This item should be answered “yes” if the client has an LPS conservator.

99. Is the client currently a conservatee under the Probate Code?

This item should be answered “yes” if the client has a conservator under the Probate Code (i.e., client was admitted or continued as client of regional center to make informed application and consent to treatment).

100. Is the client currently a dependent child of the Court (Welfare and Institutions Code Section 300 et seq.)?

This item should be answer “yes” if the client is currently a dependent child of the Court.